STATE OF MISSOURI
DEPARTMENT OF AGRICULTURE
AG BUSINESS DEVELOPMENT DIVISION

Appendix S

Senior Farmers' Market Nutrition Program- 2020 Participant Application

INSTRUCTIONS: All sections of this form are required information for participating in this program. All applications must be submitted to your local agency to determine eligibility and to receive benefits. Eligibility documents must be current.

APPLICANT INFORMATION (PLEASE PRINT)

FULL NAME OF APPLICANT	LOCAL AGENCY SITE NAME

MAILING ADDRESS

CITY	STATE	ZIP CODE	COUNTY

PHONE	ARE YOU 60 YEARS OF AGE OR OLDER?
	☐ Yes ☐ No

ETHNICITY:

- ☐ Not Hispanic/Latino
- ☐ Hispanic or Latino

RACE:

- ☐ Asian
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ American Indian or Alaska Native
- ☐ Black or African American
- ☐ White
- ☐ Other: _____

Total Number of Household Members: _____

Total Gross Income (before deductions) of All Household Members: $_____ Weekly Monthly Yearly

NOTE: SNAP (Supplemental Nutrition Assistance Program) does not count as income.

PROOF OF IDENTITY & RESIDENCY:

- ☐ Driver's License; OR
- ☐ Birth Certificate; OR
- ☐ Passport; AND
- ☐ Billing document with address

PROOF OF INCOME:

- ☐ Proof of SNAP; OR
- ☐ Proof of CSFP
- ☐ Pay stub or other statement of earnings; OR
- ☐ W-2, tax return or other tax form; AND
- ☐ Signed statement

APPLICANT CERTIFICATION

I have been advised that obtaining MoSFMNP benefits from more than one service delivery area is illegal.
I have been advised of my rights and obligations under the MoSFMNP. I certify that the information I have provided for my eligibility determination is correct, to the best of my knowledge. This certification form is being submitted in connection with the receipt of Federal assistance. Program officials may verify information on this form. I understand that intentionally making false or misleading statement or intentionally misrepresenting, concealing, or withholding facts may result in re-paying the State agency in cash the value of the food benefits improperly issued to me and may subject me to civil or criminal prosecution under State and Federal law.

Standards for eligibility and participation in the MoSFMNP are the same for everyone, regardless of race, color, national origin, age, disability, or sex.

I understand that I may appeal any decision made by the local agency regarding my eligibility for the MoSFMNP. I also understand that this application is only valid June 1, 2020 through September 30, 2020.

_____ _____

Authorized Signature Date

DESIGNATION OF PROXY (If applicable):

- ☐ Yes
- ☐ No

If yes:

The Missouri Department of Agriculture allows for eligible participants to assign one (1) proxy or authorized representative to submit an application and purchase eligible produce at a farmers' market from an authorized farmer on their behalf. One proxy per participant. The proxy may only be proxy for one eligible participant/household.

I understand that a proxy may act on my behalf to apply for MoSFMNP benefits and to pick up produce at a farmers' market from an authorized farmer.

I certify that I have read and understand the rules of having a proxy and agree to abide by the rules. I understand that my proxy may not proxy for any other party and may only go to the farmers' market in my place.

_____ _____
Signature of Participant Date

_____ _____ _____
Name of Proxy (Print) Proxy Signature Date

USDA NONDISCRIMINATION STATEMENT:

In accordance with Federal civil rights laws and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.) should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing, or have speech disabilities may contact USDA through the Federal Relay Service at (800)877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.giv/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to the USDA by:

(1) Mail: U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410
(2) Fax: (202) 690-7442; or
(3) Email: program.intake@usda.gov.

This institution is an equal opportunity provider.

TO BE COMPLETED BY PROGRAM STAFF

ELIGIBILITY:	DETERMINATION:	
Income verification ☐ SNAP ☐ SSI ☐ Bank Statement ☐ Pay Stub ☐ Income Tax Return ☐ Other:_____ Age ☐ Yes ☐ No Residency in service area ☐ Yes ☐ No	☐ Eligible ☐ Eligible – Waiting List ☐ Not Eligible ☐ Letter sent: _____ Date the Application Notification, including the Applicant Agreement, Rights, Obligations and Fair Hearing Request, were given: _____	Determination Date: _____ _____ Signature of Local Agency Staff Member _____ Name of Local Agency Staff Member (Print)